PART Ins 1901 MINIMUM STANDARDS FOR ACCIDENT AND HEALTH INSURANCE

Ins 1901.01 Scope. As specified in Ins 1901.08 of this part, the provisions of this part shall apply to all accident and health insurance and coverage's as defined in RSA 415-A:1 sold or renewed in this state, except, it shall not apply to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this part nor shall Ins 1901.03 be applicable to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance.

Ins 1901.02 Definitions.

(a) "Active recipient of mental health services" means an insured, subscriber or member of a replacing carrier's health insurance benefit plan who received mental health services from a mental health provider while covered by the prior carrier's benefit plan provided such services were received for a purpose other than monitoring medications and were received at least as often as:

(1) In the case of outpatient services:

a. For 2 separate days during the 30 day period immediately prior to the effective date of the replacing carrier's plan; or

b. For 3 separate days during the 90 day period immediately prior to the effective date of the replacing carrier's plan; or

c. For 5 separate days during the 12 month period immediately preceding the effective date of the replacing carrier's plan; and

(2) In the case of inpatient services, one impatient confinement during the 12 month period immediately prior to the effective date of the replacing carrier's plan.

(b) "Adverse underwriting decision" means any action that results in either a denial of coverage, a limitation of coverage that would not apply to other insureds who have a dissimilar health history, or an additional premium or rating that is assessed because of an individual's health history or condition.

(c) "Commissioner" means the insurance commissioner.

(d) "Department" means the New Hampshire insurance department.

(e) "Forms" means policies, contracts, riders, endorsements and applications as provided in RSA 415, RSA 419 and RSA 420.

(f) "Insurer" means an insurance corporation licensed by this department to transact a business of accident and health insurance, including nonprofit service corporations.

(g) "Medicare" means Title XVIII of the Social Security Act of 1965, as amended.

(h) "Mental health provider" means any professional or institution listed under RSA 415:18-a, IV.

(i) "Policy" means the entire contract between the insurer and the insured including the policy, riders, fraternal certificates, endorsements and the application, if attached, and also includes subscriber contracts issued by nonprofit service corporations.

Ins 1901.03 Minimum Standards for Accident and Health Insurance Benefits.

(a) The following minimum standards for benefits are prescribed for the categories of coverage specified in the following subparagraphs. Unless otherwise specifically stated, no policy of accident or accident and health insurance shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for any one of the categories of coverage listed in subparagraphs (1) through (7). But, nothing in this section shall preclude the issuance of any policy or contract which combines 2 or more of the categories of coverage listed in subparagraphs (1) through (7). However, in the event that any policy or contract delivered or issued for delivery in this state shall include 2 or more categories of coverage, it shall be required to meet the prescribed minimum standards with respect to each category of coverage so included.

(b) The above notwithstanding, if the commissioner shall find that a policy not meeting the prescribed minimum standards will nevertheless be in the public interest, the commissioner may approve such policy for delivery or issue for delivery in this state subject to whatever conditions the commissioner may deem reasonable. Nor shall this section apply to any group or blanket policy where any portion of the premium is paid from an employer's funds or from funds contributed by an employer. Neither shall this section be interpreted to preclude the possibility of approval of certain policy or contract forms that are not classifiable within the specified categories of coverage provided such policies otherwise comply with the provisions of this part and other applicable laws and parts.

(1) "Basic hospital expense coverage" when included as a category of coverage in a policy shall provide coverage subject to no deductible in excess of $100 for a period of not less than 30 days for any continuous hospital confinement of each covered person for services rendered while confined in a hospital, or in the case of a nonprofit service corporation, for services rendered while confined in a member hospital, for necessary treatment because of sickness or injury for at least:

a. Daily room and board, consisting of bed and board, including general nursing care and special diets in an amount not less than the lesser of a specified percentage of the average semiprivate room rate in the community where the insured resides or a specified dollar amount per day;

b. Miscellaneous hospital services, during each period of continuous hospital confinement for which room and board charges are payable, in an amount not less than a specified amount or percentage of the charges incurred up to a maximum limit for at least:

1. The use of operating, recovery and cystoscopic rooms and equipment;

2. The use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;

3. Diagnostic and therapeutic items such as drugs and medications, sera, biologicals and vaccines, intraveneous preparations and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;

4. Dressing and plaster casts;

5. Supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person; and

6. Any medical services or supplies which are customarily provided by hospitals unless specifically excluded in the insurance or subscriber contract or in the individual certificates issued in connection with group insurance;

c. Outpatient services, consisting of:

1. Hospital services on the day surgery is performed to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

2. Hospital services rendered within 24 hours after an accidental injury in an amount up to a maximum of not less than a specified dollar amount per each such injury; and

3. X-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital up to a specified dollar maximum per disability or per calendar or policy year;

(2) "Basic medical-surgical expense coverage" when included as a category of coverage in a policy shall provide coverage for service rendered by a physician, or in the case of a nonprofit service corporation a participating physician, to each covered person for sickness or injury for at least the following:

a. Surgical services consisting of operating and cutting procedures for the treatment of a sickness or injury, and endoscopic procedures including any pre-or post-operative care usually rendered in connection with such operation or procedure, in an amount not less than:

1. A specified percentage of the reasonable charges; or

2. If specified in dollar amounts, a fee schedule based on an acceptable relative value scale of surgical procedures up to a specified dollar maximum for any one procedure;

b. Anesthetic services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician performing the surgical service or his assistant, in an amount not less than the lesser of a specified percentage of the reasonable charge, which percentage shall be the same as that specified for surgical services, or 15 percent of the benefit provided as a specified dollar amount for that operation or procedure pursuant to Ins 1901.03(b)(2)a.

c. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical or pregnancy care is required, in an amount not less than the lesser of:

1. A specified percentage of the reasonable charges; or

2. A specified dollar amount per day, in either case for not less than 30 days per each continuous period of confinement.

(3) "Hospital confinement indemnity coverage" when included as a category of coverage in a policy shall provide daily benefits for hospital confinement on an indemnity basis, with or without an elimination period, in an amount not less than the dollar amount per day specified in the policy and for not less than 31 days during any one period of confinement for each person insured under the policy.

(4) "Major medical expense coverage" when included as a category of coverage in a policy shall provide hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000; co-payment by the covered person not to exceed 25 percent of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5 percent of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefit provided by such underlying insurance, for each covered person for at least:

a. Daily hospital room and board expenses, as defined in Ins 1901.03(b)(1)a. of this part, prior to application of the co-payment percentage, for not less than a specified dollar amount per day for a period of not less than 31 days during continuous hospital confinement;

b. Miscellaneous hospital services, as defined in Ins 1901.03 (b)(1)b. prior to application of the co-payment percentage, for an aggregate maximum of not less than that specified in the policy as either an aggregate dollar amount or a multiple of the daily room and board rate when such rate is specified in dollar amounts;

c. Surgical services, as defined in Ins 1901.03(b)(2)a. prior to application of the co-payment percentage, for a maximum of not less than a specified dollar amount for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

d. Anesthetic services, as defined in Ins 1901.03 (b)(2) b. prior to the application of the co-payment percentage, for a maximum of not less than 15 percent of the covered surgical fees, or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used in the surgical schedule;

e. In-hospital medical services, as defined in Ins 1901.03(b)(2) c. with minimum dollar amounts per visit, prior to the application of the co-payment percentage, equal to not less than a specified dollar amount per visit covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than the dollar amount specified;

f. Outpatient services, provided by a hospital, to include:

1. Hospital services on the day surgery is performed;

2. Hospital services rendered within 24 hours after accidental injury; and

3. Diagnostic x-ray and laboratory services, radiation therapy and hemodialysis ordered by a physician.

g. Out-of-hospital care, consisting of:

1. Physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury; and

2. Diagnostic x-ray and laboratory services, prescription drugs, radiation therapy and hemodialysis ordered by a physician.

h. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances, except replacements thereof, and rental and/or purchase of durable medical equipment required for therapeutic use.

i. Benefits for other medical expenses to include at least 3 of the following:

1. The services of a registered graduate nurse, R.N., other than a nurse who ordinarily resides in the insured's home or is a member of the insured's or the insured spouse's family;

2. Physical therapy;

3. Professional ambulance service when used to transport the individual from the place where he is injured by an accident or stricken by a disease to the first hospital where treatment is given;

4. Convalescent nursing home care;

5. Treatment for functional nervous disorders, and mental and emotional disorders; or

6. Unless otherwise prohibited by law, the above benefits may be subject to a co-insurance percentage of 50 percent and may be further limited by internal limits on such covered charges and a maximum limit applicable to each such covered charge.

(5) "Disability income protection coverage" when included as a category of coverage in a policy shall provide for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from sickness or injury or a combination thereof.

(6) "Accident only coverage" when included as a category of coverage in a policy shall provide coverage, either singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident.

(7) "Specified disease coverage" when included as a category of coverage in a policy shall provide coverage for each person insured under a policy for a specifically named disease, or diseases, or for procedures or treatments unique to specified diseases. This category of coverage will be permitted as the only category of coverage provided by a policy of accident and health insurance when the policy is issued under a franchise plan. For the purposes of this part, accident and health insurance under a franchise plan is considered to be that insurance which is defined in and which complies with all requirements of RSA 415:19. When the "specified disease" category

of coverage is provided in any policy of accident and health insurance that is not issued under a franchise plan, such policy must also provide insurance which meets the minimum standards stated under Ins 1901.03(b) for at least one of the following categories of coverage - basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, or major medical expense coverage. Whenever provided in any policy, "specified disease coverage" shall be in addition to any other benefits provided by the policy. It is further provided, however, that the commissioner of insurance may approve additional methods of marketing for this category of coverage, if it is deemed to be in the public interest.

(8) "Specified accident coverage" when included as a category of coverage in any policy shall provide coverage for a specifically identified kind of accident, or accidents, for each person covered under the policy, either singly or in combination for death, dismemberment, disability, or hospital and medical care caused by the accident, or accidents, specified.

Ins 1901.04 Minimum Standards for Accident and Health Insurance Policy Provisions. The following minimum standards for policy provisions shall be in addition to, and in accordance with, applicable laws of this state, including RSA 415.

(a) No accident and health insurance policy or nonprofit service corporation subscriber contract delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below unless such definitions comply with or are not less favorable than the requirements of this section. If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(1) "Accident", "accidental injury", "accidental means", shall employ result language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause and which occur while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under any worker's compensation, employer's liability or similar law, motor vehicle no fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(2) "Complications of pregnancy" shall be defined to mean:

a. Conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

(3) "Continuous period of confinement" means consecutive days of in-hospital or extended care facility service received as a registered patient, or successive confinements for the same or related causes when discharge from and readmission to the hospital or extended care facility occurs within a 180-day period.

(4) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

1. Be operated pursuant to law;

2. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

3. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

4. Provide continuous 24-hours-a-day nursing service by or under the supervision of a registered graduate professional nurse, R.N.; and

5. Maintains a daily medical record of each patient.

b. The definition of such home or facility may provide that such term shall not be inclusive of:

1. Any home facility or part thereof used primarily for rest;

2. A home or facility for the aged or for the care of drug addicts or alcoholics; or

3. A home or facility primarily used for the care and treatment of mental diseases, disorders or custodial or educational care.

(5) A policy may not require that a hospital be licensed, unless licensing is required where the insured resides or where the hospital is located, that it be incorporated, or that it be recognized by certain accrediting organizations such as the American Hospital Association. The policy may require that a hospital:

a. Be operated pursuant to law or legally operated;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities, except a legally operated institution for the treatment of chronic diseases, for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made;

c. Provide 24 hour nursing service by or under the supervision of a registered nurse, R.N.; and

d. Maintain permanent medical history records.

The definition may exclude institutions operated by the Veteran's Administration or other U. S. Government agencies; or which are rest homes, convalescent centers, even if part of the hospital itself, homes for the aged or insane or institutions for the care and treatment of chronic alcoholism or drug addiction.

A policy may not exclude a hospital because it is operated by a state, county, city or other political subdivision.

(6) "Mental or nervous disorders" shall be defined as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(7) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse, R.N., a licensed practical nurse, L.P.N., or a licensed vocational nurse, L.V.N. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual, other than a nurse who ordinarily resides in the insured's home, or is a member of the insured's or insured's spouse's family, who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of, this state.

(8) "Partial disability" shall be defined in relation to one's inability to perform some part or all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or "compensation."

(9) "Participating physician" means any duly licensed physician with whom a nonprofit service corporation has an agreement with respect to the rendering of services to subscribers of such corporation.

(10) "Physician" may be defined by including words such as "duly licensed physician" or "duly qualified physician". In using such terms an insurer is required to recognize and to accept, to the extent of its obligation under the contract, services rendered by those providers of medical care and treatment specifically named in RSA 415:5, I(8) and RSA 415:18, VI., when such services are within the scope of the providers' licensed authority.

(11) "Probationary period" may not be defined to be more restrictive than the following. "Probationary period" means a specified number of days or months after the date of issuance of the policy during which coverage is not afforded for sickness.

(12) "Sickness" shall not be defined to be more restrictive than the following. "Sickness" means sickness or disease of an insured person which first manifests itself, or words of similar import, after the effective date of insurance and while insurance is in force. Wording such as "the cause of which originates" will not be permitted. An individual or franchise policy may provide in such definitions for a probationary period which will not exceed 30 days from the effective date of coverage of a newly-added family member, except in the case of a newborn child. The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employer's liability or similar law.

(13) "Total disability" shall be defined as follows:

a. A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit;

b. "Total disability" may be defined in relation to the inability of the person to perform duties but such inability may not be based solely upon an individual's ability to:

1. Perform "any occupation whatsoever," or "any occupational duty," or "each and every duty of his occupation"; or

2. Engage in any training or rehabilitation program.

c. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require regular care and attendance by a physician, other than the insured or a member of the insured's immediate family. The definition may require that the disability be "continuous" or "uninterrupted" for a specified period of time or to a specified age which shall be consistent with the type of coverage afforded.

(b) Rules respecting policy provisions-individual accident and health are as follow:

(1) The terms of renewability for each individual or franchise policy or nonprofit service corporation subscriber contract shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision must be consistent with the requirements specified below for the type of contract to be issued. Such provision must be appropriately captioned and commence or be referenced to on the first page of the policy and must clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

a. Policies that are noncancellable and guaranteed renewable must state clearly the period of time during which they are to be guaranteed renewable and must provide the following during such time period:

1. The company cannot cancel or refuse to renew the policy;

2. The company cannot increase the premium scale from the scale stated in the policy; and

3. If such a policy covers both husband and wife, the age of the younger spouse must be used as the basis for fulfilling the age, at least to age 50, or durational, for at least 5 years if issued after age 44, requirements of the definitions of "noncancellable" and "guaranteed renewable" policies for the purposes of defining the period of guaranteed renewability of the policy. This requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

b. Policies that are guaranteed renewable must state:

1. The age or term for which the form is guaranteed renewable, if other than lifetime;

2. That applicable premium rates may be changed by class;

3. That the company cannot refuse to renew the policy before its expiry date;

4. If such a policy covers both husband and wife, the age of the younger spouse must be used as the basis for fulfilling the age, at least to age 50, or durational, for at least five years if issued after age 44, requirements of the definitions of "guaranteed renewable" policies for the purposes of defining the period of guaranteed renewability of the policy. This requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition;

c. Renewable subject to consent of company and variants thereof is as follows:

1. The renewal provision of a policy characterized as subject to the consent of the company shall be appropriately captioned by the use of words such as "renewable subject to the consent of the company" or words of similar import;

2. With respect to such policies, the insurer's attention is directed to the provisions of RSA 415:6, II(8) and Ins 401.01(c)(1)c.13;

3. Policies with a qualified right of renewal are as follows:

(i) A renewal provision, other than enumerated above, may grant to the insured the right of renewal by timely payment of premiums up to a stated age, if any, subject to the reserved right of the insurer to terminate all such policies on a specified basis upon the giving of a specified period of notice, which shall be set forth in the appropriate policy provision;

(ii) The right of the insured to renew the policy may be conditioned upon the continuation of a specified status, e.g. an employee of a named employer, member of a named organization, while engaged in a specific occupation associated with such employment or such organization, residence in a given state or geographical area, insured under a given form of insurance having like form number identification;

(iii) The rights of the insured and of the insurer shall be clearly set forth in the renewal provision. Such shall include the specified age limit, if any, requirements as to the professional or occupational status, if any, and requirements as to the continuing relationship, if any, of the employee or member; and

(iv) Continuance of insurance after the insured ceases to be eligible for coverage under the plan may be at the option of the insurer. In the event a different table

of premium rates is to be applicable with respect to renewals occurring thereafter, such fact shall be declared in the renewal provision.

4. A policy characterized as a "single term nonrenewable policy" shall be appropriately identified as such by a separate policy provision. Such provision must identify or reference the proper part of the contract within which the term, duration, of the coverage is specified.

5. Policies which may not be characterized as "noncancellable and guaranteed renewable" or "guaranteed renewable" under existing definitional requirements solely because such policy may not be continuable to age 50 or for a minimum period of 5 years, may use a renewal provision caption, subject to the approval of the commissioner, which states that the right of renewal is vested in the insured, e.g. policies issued to afford coverage for family income protection, mortgage payments or temporary debt obligations for a stated period of years, to a stated age, to the occurrence of a stated event or during the continuance of a given status, e.g. employment, membership.

6. Policies which provide a qualified right of continuancy after expiration of the period during which such policy is noncancellable and guaranteed renewable or guaranteed renewable must clearly specify the conditions, such as continued gainful employment, which must be fulfilled to permit continuance of the policy. If premiums are to be based on an attained age or on a step rate basis, such must be declared in the renewal provision. The age limit, if any, to which any policy may be renewed shall be declared in the renewal provision.

(2) Initial and subsequent conditions of eligibility are as follows:

a. A family policy providing hospital, surgical, medical expense, hospital confinement indemnity, or accident only insurance shall include provisions which specify the identity and qualifications applicable to those family members who may become insured under the policy initially or by subsequent addition;

b. Eligible family members may include:

1. The insured;

2. The insured's spouse; or

3. Natural and/or adopted children of the insured and of the insured's spouse who are under a specified age not to exceed age 18 unless a dependency test is specified.

c. The provisions concerning eligibility shall, for persons who may become insured subsequent to policy issuance, state the conditions under which such coverage may become effective, such conditions may include:

1. Qualifications for automatic coverage and the duration thereof;

2. Required evidence of insurability;

3. The necessity of application or notice from the insured;

4. Any requirements as to the payment of premiums as to such addition; and

5. The time within which action is to be taken by the insured.

d. In family policies providing for the addition of newly eligible family members, the time limit on certain defenses provision may be modified to provide for a new contestable period for each new member so added, but shall not provide for a new contestable period for the policy.

e. A family policy providing benefits for accidental injuries, e.g. accidental death, dismemberment, loss of sight, indemnity for fractures or dislocations, blanket medical expense, etc., shall include provisions which specify the identity and qualifications applicable to those family members who may become insured under the policy initially or by subsequent addition. Provisions describing eligibility of family members, the adding of family members and the termination of insurance as to such family members will generally follow the pattern specified in Ins 1904.01(b)(2) and (3). Generally, causes of termination of coverage of individual family members will be predicated on age and/or cessation of dependency which would include legal separation, termination of marriage by divorce and similar items.

(3) Terminations of insurance of a family policy providing hospital, surgical, medical expense, hospital confinement indemnity or accident only insurance shall include provisions which shall specify:

a. As to the insured, the age or event, if any, upon which coverage under the policy will terminate, e.g. age 65, eligibility for medicare;

b. As to the spouse, the age or event, if any, upon which coverage under the policy will terminate, e.g. age 65, eligibility for medicare, legal separation, divorce or annulment;

c. As to a child, the age or event upon which coverage under the policy will terminate, e.g. age 21, marriage of the child, cessation of dependency;

d. A noncancellable and guaranteed renewable or guaranteed renewable policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The provisions shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured;

e. If any such policy, in accord with a., b. or c. above establishes an age or event upon which coverage under the policy will terminate, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted, except where such acceptance was predicated on a misstatement of age as outlined in RSA 415:13.

f. The provisions shall provide that, in the event of cancellation by the insurer, where permitted by law, or refusal to renew by the insurer of a policy providing pregnancy

benefits, such policy shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy continued in force;

g. The provisions shall provide that termination of the policy by the insurer shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured person, limited to the duration of the policy benefit period, payment of the maximum benefits, or for a time period of not less than 3 months; and

h. The termination provision may provide for the termination or suspension of coverage if the family members become eligible for coverage provided by the federal government or a state government.

(4) Non-duplication of coverage provisions are as follows:

a. All individual accident and health insurance policies issued or delivered in this state shall comply with RSA 415:6, II(4), RSA 415:6, II(5), or RSA 415:6, II(6), whichever is applicable; and

b. It is the position of this department that the statutory provisions cited above do not preclude the issuance or delivery of variable deductible policies designed to cover losses in excess of those covered by basic coverage.

(5) Preexisting conditions provisions are as follows:

a. The policy must clearly disclose the intent of the insurer as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the policy is not to be applicable to preexisting conditions, the policy shall specify, in substance that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sickness is limited to that which manifests itself subsequent to the effective date of coverage or expiration of the probationary period, if any;

b. In the administration of claims with respect to preexisting conditions, no claim shall be reduced or denied on the ground that the disease or physical condition for which claim is made preexisted the effective date of coverage unless the insurer had evidence that such disease or physical condition had manifested itself prior to the effective date of the benefit provision applicable thereto. Such manifestation may be established by proof, evidence, or information of:

1. Medical diagnosis or treatment of such disease or physical condition prior to the effective date of the benefit applicable thereto; or

2. The existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

c. The defense predicated on preexistence is subject to and limited by RSA 415:6, II(2)(a) and 415:6, II(2)(b). In accordance with RSA 415-A:5, no insurer shall use a time limit in excess of 12 months after date of issuance where the application for such insurance does not

seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.

(6) Probationary or waiting periods are as follows:

a. Probationary or waiting periods shall relate to that period of time which may be specified in the policy and which shall follow the date a person is initially insured under the policy, or following reinstatement of a policy, before the coverage or coverage's of the policy shall become effective as to such person. A probationary or waiting period shall not be used with respect to any loss resulting from accidental injuries as defined in the policy; however, as to loss resulting from sickness, a policy may specify a probationary or waiting period which shall not exceed 30 days except as follows:

1. For pregnancy benefits - 9 months except that premature delivery or complications of pregnancy shall be covered within 9 months if the expected date of delivery is after 9 months; alternatively, a 30 day probationary or waiting period may be used where such probationary or waiting period is expressed in terms of the inception of pregnancy; or

2. Six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of the adenoids, tonsils, appendix, varicose veins, or the male or female generative organs, may not be limited to females. However, the permissible 6 months probationary or waiting period shall not be applicable where such specified diseases or conditions are treated on an emergency basis; and

3. Policies or contracts may provide for a 9 month waiting period for losses resulting from transplant surgery, except that disability income or overhead expense policies may not provide for a waiting period greater than 6 months in the case of loss resulting from transplant surgery.

b. This subsection shall not apply to benefits for vision or dental care.

(7) The limitations on the risk undertaken, whether applicable to amounts, duration of benefits of age or other matters, must be specified with clarity and certainty in the appropriate provision of the contract.

(8) Exceptions, exclusions and reductions are as follows:

a. An exception or exclusion is any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of risk not assumed under the terms and provisions of the contract;

b. A reduction is a provision which takes away some portion, but not all of the coverage of the policy under certain specific conditions. Such relates to a risk assumed by the insurer but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used;

c. Exceptions, exclusions and reductions shall be clearly expressed as a part of the benefit provision to which such applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately captioned. The use of general policy exclusions and the scope thereof will, of necessity, vary with the type of benefits afforded in a given policy. Such may generally be classified as "result" or "status" types;

d. If otherwise permitted by law, exceptions and exclusions contained in policies will be considered acceptable if such are deemed reasonable and appropriate to the risk undertaken and are approved by the commissioner. No policy shall limit or exclude coverage's by type of illness, treatment, or medical condition if such limitations or exclusions are counter to the standards set forth in this part;

e. The listing of specified exclusions or exceptions in a policy shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical conditions or extra hazardous activities. Where waivers are required as a condition of issuance or reinstatement, signed acceptance by the insured is required, unless, in the case of direct writers only, on initial issuance, the full text of the exclusion is contained on the first page or the specifications page of the policy. When the text of such an exclusion appears on the specifications page, or schedule page, the words "see exclusion(s) on the specifications page" shall be added by rubber stamp to the brief policy description on the first page of the policy; and

f. If a policy contains a military service exclusion or a provision suspending coverage during military service, and if the premiums are either reduced or refunded for the period of such military service, the policy shall clearly so state.

1. As to policies other than noncancellable and guaranteed renewable and guaranteed renewable or guaranteed renewable policies the following shall apply:

(i) If the policy contains a "status" type of exclusion which excludes all coverage's applicable to an insured person while in military service on full time active duty, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis;

(ii) If the policy contains a "causation" type exclusion, loss resulting from military service, while an insured is on full time active duty, refund of premium is not necessary since the policy would be operative as to any other loss not resulting from military service causes; and

(iii) A provision for voluntary suspension of coverage as to an insured person during military service may be used and if an identifiable premium is charged as to such person, then upon written request for suspension a pro rata premium must be refunded.

2. As to noncancellable and guaranteed renewable and guaranteed renewable policies the following shall apply:

(i) The policy may provide for refund of the entire premium for the period of military service or for a partial refund of the premium from the date the insurer

receives notice and it may adjust any such refund for any change in reserves during the period of suspension;

(ii) The policy may contain a military service exclusion or may provide for suspension of coverage upon entry into military service with the right of reinstatement upon termination of such service within a specified period of not less than 60 days without evidence of insurability; and

(iii) The insurer may charge a partial premium during the period of suspension which will anticipate accumulation of reserves required by law or regulation and related cost factors.

(9) "Elimination period" means the initial period of time during the continuance of a condition insured against and specified in respect to a particular benefit, for which such benefit will not be paid. Such periods must be clearly expressed in the policy schedule or benefits page and clearly expressed or referenced in the benefit provision to which such elimination period appears.

(10) A policy may contain provisions relating to recurrent confinements or recurrent disabilities; provided, however, a recurrent confinement or recurrent disability provision may not specify that such confinement or such disabilities be separated by a period greater than 6 months.

(11) If a policy contains a conversion privilege, it shall comply, in substance, with the following:

a. The caption of the provision shall be "conversion privilege", or words of similar import. The provision shall indicate the persons eligible for conversion. The circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised, shall be described in the provision. The provision may indicate that the privilege is subject to the underwriting standards of the insurer relating to overinsurance;

b. A business overhead expense policy issued on either a guaranteed renewable basis, or a noncancellable basis, or renewable at the option of the company basis may, at the option of the insurer, contain a conversion privilege exercisable upon termination of the business interest, or it may provide for its continuation as a loss of time policy; and

c. When a policy is issued pursuant to the exercise of a conversion privilege contained in a group, individual family or another individual policy, the converted policy or a rider attached thereto shall reflect the relative rights of each person covered under the converted policy.

(12) Requirements for replacement are as follows:

a. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used;

b. An agent soliciting the sale of an individual accident and health policy is charged with the responsibility of making a reasonable effort to determine the existence of other insurance and if the sale of the policy he is soliciting will result in replacement. An agent soliciting

the sale, upon determining that the sale would involve replacement, shall furnish to the applicant, at the time of taking the application, the notice described in d. below. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall accompany or be made part of the application and be retained by the insurer;

c. An agent or insurer soliciting the sale of insurance through direct response shall include within the solicitation material the notice described in d. below. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall accompany or be made part of the application when it is returned to the insurer for his retention; and

d. The notice required by b. and c. above shall provide in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF
ACCIDENT AND HEALTH INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by the _____ insurance company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

(a) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in a claim for benefits being denied or reduced under the new policy, whereas the same claim might have been payable under your present policy. Or, even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(b) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(c) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

(d) Finally, before you terminate your present policy, be certain that your application for the new policy has been accepted by the replacing company.

The above "Notice to Applicant" was delivered to me on:

_____
(date)

_____
(Applicant's Signature)

(e) This subsection shall not apply to policies issued pursuant to a conversion privilege or to accident only policies.

(f) Rules respecting policy provisions-group and blanket accident and health insurance are as follows:

(1) In the event of any renewal rate increase, the insurance company shall provide the policyholder with at least 30 days prior notice of any such increase;

(2) Declination of renewal or termination of insurance are as follows:

a. No insurer may decline to renew a group policy unless the cause of its action is based on one or more of the reasons for declination of renewal stated in the policy. Any such reason that shall be stated in a group policy will be objective in nature, and declination of renewal shall be defined so as to include any termination of a group policy by the insurer for any reason except for nonpayment of premiums; and

b. Notice of nonrenewal or termination of a group or blanket policy by the insurer shall provide for at least 30 days prior notice.

(3) Non-duplication of coverage and subrogation provisions are as follows:

a. Non-duplication or coordination of benefit provisions for group or blanket medical expense insurance coverage's may provide for non-duplication or coordination with any plan or government program providing benefits or services for, or by reason of, medical or dental care and treatment which benefits or services are provided by group or blanket insurance or any other arrangement of coverage of persons in a group whether on an insured or uninsured basis. All policies with these provisions shall stipulate clearly how these provisions will be administered and shall be at least as favorable to the insured as the rules promulgated by the commissioner under Ins 1904;

b. Group or blanket policies providing medical expense insurance coverage's may include subrogation provisions or provisions that are similar in their intent and purpose;

c. Group policies generally referred to as group excess policies are prohibited, since they contain non-duplication provisions less favorable to the insured than the rules promulgated under Ins 1904. A group excess policy is herein defined as insurance covering only that part of a loss in excess of coverage provided by other insurance carriers. This prohibition shall not apply to any policy which excludes coverage payable under another policy issued to the policyholder on behalf of the same, or a class of, insureds under another policy;

d. As an exception to the prohibition in c. above, student accident insurance policies written on either a group or blanket basis, may include a non-duplication provision stating that covered medical expenses shall not include any charges or medical expenses to the extent that they are compensable under any other group or blanket health insurance plan in this or any other insurer or service organization if total covered expenses exceed $100. Such student accident policies shall be considered primary with respect to covered expenses of $100 or less regardless of other insurance; and

e. As a further exception to c. above, group or blanket policies providing insurance community-based volunteer groups such as youth groups, volunteer fire departments or

youth athletic teams may be written on an excess basis but only if all premiums due under the policy are paid entirely by the sponsoring organization.

(4) Preexisting conditions are as follows:

a. With respect to basic hospital expense, basic medical-surgical expense and major medical expense coverage's, no group or blanket accident and health policy issued or delivered in this state shall include a provision limiting coverage for preexisting conditions unless such provision is at least as favorable to the insured individual as the following:

1. Eligible medical expenses shall not include charges incurred in connection with a sickness, disease or bodily injury which required medical care or treatment during the 3 months immediately preceding the date an individual's insurance for this benefit went into force unless such charges are incurred after the first of the following to occur:

(i) A period of 3 consecutive months ending while the individual's insurance for this benefit is in force and during which he incurred no medical care or treatment expenses in connection with the sickness, disease or bodily injury;

(ii) A period of 12 consecutive months during which the individual was continuously insured for this benefit; and

(iii) In the case of an employee or member a period of 6 consecutive months during which he was continuously insured for this benefit and actively at work on a full time basis; provided, however, that the above shall not apply to dental expense benefits.

b. In the administration of claims with respect to preexisting conditions, no claim shall be reduced or denied on the ground that the disease or physical condition for which claim is made preexisted the effective date of coverage unless the insurer has evidence that such disease or physical condition had manifested itself prior to the effective date of the benefit provision applicable thereto. Such manifestation may be established by proof, evidence or information of a medical diagnosis or treatment of such disease or physical condition prior to the effective date of the benefit applicable thereto.

(5) With respect to group or blanket accident and health policies, no probationary or waiting periods shall be permitted, except with respect to pregnancy, except for complications thereof, dental or vision care benefits. Any probationary or waiting period for pregnancy shall be at least as favorable to the insured as that period stated under Ins 1901.04(b)(6)a.1.

(6) The limitations on the risk undertaken, whether applicable to amounts, duration of benefits or age or other matters, must be specified with clarity and certainty in the appropriate provisions of the policy and the certificate.

(7) Exceptions, exclusions and reductions are as follows:

a. Exceptions, exclusions and reductions, for the purposes of this subsection shall be defined in accordance with Ins 1901.04(b)(8)a. and b;

b. Exceptions, exclusions and reductions must be clearly expressed in both the policy and the certificate as a part of the benefit provision to which such applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately captioned; and

c. Exceptions, exclusions and reductions included in any policy or certificate shall be considered acceptable where such are deemed reasonable and appropriate to the risk undertaken and are approved by the Commissioner.

(8) "Elimination period" shall have the same meaning with respect to group or blanket accident and health insurance policies as that prescribed in Ins 1901.04(b)(9) relating to individual policies.

(9) Successive periods of disability are as follows:

a. No group or blanket accident and health policy shall be issued or delivered in this state unless the provision defining successive periods of disability shall be at least as favorable to the insured individual as the following: "For the insured employee, or member, successive periods of hospital confinement or successive operations due to the same or related sickness or injury, if separated by 30 days or more of active full time work, shall be considered separate periods of disability. For dependents of the insured employee, or member, successive periods of hospital confinement or successive operations due to the same or related sickness or injury shall be considered one period of disability if separated by less than 6 months.

b. With respect to group or blanket benefits providing weekly or monthly loss-of-time or salary reimbursement payments in the event of disability, when the insured employee, or member, shall resume active, full time employment any subsequent period of disability resulting from the same or related cause shall be considered a new period of disability if the resumption of full time employment was for a continuous period of 6 months or more when the benefit duration of the plan exceeds 2 years; and, if the benefit duration of the plan is 2 years or less, any subsequent period of disability resulting from the same or related cause shall be considered a new period of disability if the employee, or member, resumed active, full time employment for a period of 30 days or more.

(10) Conversion privileges are as follows:

a. Any employee or member entitled to exercise the conversion privilege required by RSA 415:18, VII, IX, X, XI, shall whenever eligible therefore, have the option of choosing one or both of the following plans:

1. A minimum conversion plan hospital room and board expense benefit of $100 per day for a maximum period of 90 days; miscellaneous hospital expense benefits of a maximum of $1,000; and surgical expense benefits according to a $1,000 maximum benefit schedule;

2. A major medical plan providing a lifetime or per illness maximum at least equal to that provided by the group policy or $250,000, whichever is lower, and payment of benefits at the rate of 80 percent of covered medical expenses in excess of a $500 deductible or the benefits deductible, if greater, until 20 percent of such covered

expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100 percent during the remainder of the benefit period or calendar year; and

3. The requirement established by Ins 1901.04(c)(10)a., shall not prohibit the offering by insurers of additional plans that exceed these minimum benefits.

b. Conversion policies issued pursuant to RSA 415:18, IX, X and XI shall comply with Ins 1901.04.

c. Applications for conversion policies shall not include any health questions of any kind with respect to the person or persons entitled to conversion.

d. At the option of the employee or member, conversion policies issued pursuant to RSA 415:18, VII, shall include maternity benefits for the dependents of such employee or member who were covered under the group policy provided that maternity benefits for such dependents were provided by the policy from which conversion is being made. Whenever the employee or member is entitled to include maternity benefits in the conversion policy, such benefits shall be offered by the insurer but in no event shall the employee or member be entitled to a maternity benefit exceeding that provided for such persons under the group policy from which conversion was made. In those cases where the policy from which conversion is being made provided maternity benefits on a "switch" basis, a female employee or member shall be entitled to include maternity benefits in the conversion policy provided that her spouse was covered as a dependent under the policy from which conversion is being made.

e. An insurer may refuse to renew any conversion policy if any person insured under such policy becomes eligible for benefits under the Federal Social Security Act or, if any person insured under such policy becomes overinsured in accordance with the insurer's standards on file with the commissioner, except that nonrenewal due to overinsurance shall not be permitted after the conversion policy has been in force for 2 years.

f. Standards of overinsurance filed by an insurer with the commissioner must be at least as favorable to the insureds as the following definition of overinsurance: "overinsurance" means, with respect to any person, that his or her health care coverage under the converted policy and all duplicating plans would be more than the applicable maximum set forth below:

1. As to hospital room and board expense coverage, $10 a day in excess of the average cost of semiprivate accommodations in the area where that person lives;

2. As to surgical expense coverage the usual and customary charges made for surgical procedures in the area where that person lives; and

3. As to major medical coverage, another major medical policy other than one with a deductible of $5,000 or more.

g. "Duplicating plans", as used in the above definition of "overinsurance", shall mean any one or more of the following plans which pays benefits or provides services for health care coverage: any other hospital, surgical or medical expense insurance policy; any nonprofit service corporation subscriber contract or medical practice or other prepayment plan; any

other plan or program whether insured or uninsured, and whether voluntary or required by any statute except Medicaid; except, under no circumstances will any plan which includes any limitation or exclusion applicable to any specific preexisting health condition of the insured be considered as a duplicating plan for purposes of determining overinsurance.

h. Before any insurer may exercise its privilege to nonrenew or an in force conversion policy if any person or persons covered by it is overinsured, or would be overinsured, the insurer shall give the insured written notice at least 30 days in advance of a renewal date that the insured may elect, prior to that renewal date, any of the alternatives to nonrenewal appearing below:

1. To have the person or persons overinsured eliminated from the conversion policy's coverage;

2. To terminate the duplicating plan or plans to the extent necessary to reduce the total coverage below the overinsurance standards; or

3. To reduce the coverage of the conversion policy to the extent necessary for the total coverage to be below the overinsurance standards.

Ins 1901.05 Discontinuance and Replacement of Group Accident and Health Coverage.

(a) This section is applicable to insurance policies and subscriber contracts issued or provided by an insurance company or a nonprofit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions or associations. As used herein, the term "group-type basis" shall mean a benefit plan other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

(1) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;

(2) The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or in connection with the particular organization or group;

(3) There are arrangements for bulk payment of premiums or subscription charges to the insurer or nonprofit service corporation; and

(4) There is sponsorship of the plan by the employer, union, or association.

(b) Effective date of discontinuance for nonpayment of premium or subscription charges are as follows:

(1) If a policy or contract subject to these rules and parts provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period; and

(2) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period, such as, but not limited to, continuing to recognize claims subsequently incurred, the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

(c) Requirements for notice of discontinuance are as follows:

(1) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved that the carrier be immediately furnished with the full name of each certificate holder and his current mailing address. Such notice of discontinuance shall advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims or losses incurred after such date; and

(2) Such notice of discontinuance shall also advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(d) Extension of benefits for every group policy or other contract subject to this part must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract, as required by the following paragraphs of this subsection:

(1) In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement;

(2) In the case of hospital or medical expense coverage’s, other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered "reasonable" if it provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverage’s, and under other types of hospital and medical expense provides an extension of at least 90 days or an accrued liability for expenses incurred during a period of continuous total disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force, e.g., an accident;

(3) Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits.

(e) Rules requiring continuance of coverage in situations involving replacement of one carrier by another are listed below. This subsection shall indicate the carrier responsible for providing coverage in those instances in which one carrier's contract replaces a plan of comparable benefits of another:

(1) The rules specified in this subsection shall apply to a carrier replacing a benefit plan that is fully insured or that is partially self-funded and partially insured. However, these rules shall not be imposed upon a carrier replacing a benefit plan that was self-funded or self-insured;

(2) The prior carrier shall remain liable only to the extent of the accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insurer, or foregoes the provision of coverage. In no case, shall the prior carrier terminate or otherwise end an extension of benefits provided in the event of total disability when a totally disabled person becomes insured or eligible to become insured under any other group plan, whether insured or uninsured.

(3) The liability of the succeeding carrier shall be determined by the following rules:

a. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits shall be covered by that carrier's plan of benefits. Such eligibility shall be determined by reference to those provisions in the succeeding carrier's plan with respect to the classes eligible, activity-at-work and non-confinement rules, and any other provisions relative to eligibility; and

b. Each person not covered under the succeeding carrier's plan of benefits in accordance with above, shall nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered under the prior plan on the date of discontinuance;

1. No such person shall be required to furnish evidence of insurability as a condition of coverage;

2. Individuals who shall be considered "validly covered" shall include all individuals whom the employer or administrator has determined to be eligible for continuation or extension of coverage under state or federal law. In no event, shall the replacement of one carrier by another abrogate any rights any person may have under state or federal law to a continuation or extension of coverage;

3. Preliminary to the issue of coverage, it shall be permissible for a carrier to require an employer or administrator applying for coverage to identify all individuals who have elected or who are eligible to elect any federal or state mandated continuation of coverage; and

4. Before coverage is issued, it shall also be permissible for a carrier to require an employer or administrator to identify all individuals who are eligible for or are being provided an extension of benefits in the event of total disability under the extension of benefits provisions of the prior carrier's plan;

c. With reference to those individuals who were totally disabled immediately prior to the date the succeeding carrier's coverage becomes effective, the succeeding carrier shall provide benefits according to the following rules:

1. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan;

2. Coverage shall be provided for such totally disabled persons by the succeeding carrier until the date the individual's coverage would terminate in accordance with the

succeeding carrier's plan provisions applicable to individual termination of coverage for each type of coverage;

3. If, at a date earlier than the date coverage would terminate in accord with 2. above, the individual who was totally disabled becomes covered by meeting the eligibility requirements of the succeeding carrier's plan of benefits as in Ins 1901.05(e)(3)a., the provision of benefits in the manner required by Ins 1901.05(e)(3)c., 1. and 2. shall cease and benefits thereafter shall be provided as if the individual had initially been covered by the succeeding carrier through the operation of Ins 1901.05(e)(3);

4. In no event, shall the succeeding carrier terminate an individual's coverage prior to the termination date under the prior carrier's plan of the state or federal continuation or extension of benefits elected by the individual and consented to by the employer or administrator except as otherwise permitted by state or federal law; and

5. In the case of an individual who was totally disabled, coverage under Ins 1901.05(e)(3)b. and c. shall be provided by the succeeding carrier until the end of any period of extension or accrued liability which is required of the prior carrier by Ins 1901.05(d). If the prior carrier's policy or contract is not subject to Ins 1901.05(d) coverage shall be provided by the succeeding carrier to an individual who was totally disabled as of the succeeding carrier's effective date as if the prior carrier's policy or contract had been subject to Ins 1901.05(d) at the time the plan was discontinued and replaced by the succeeding carrier's plan.

d. In the case of a preexisting condition limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with these rules during the period of time this limitation applies under the new plan shall be the lesser of benefits of the new plan determined without application of the preexisting conditions limitation or the benefits of the prior plan as would have been determined by the prior carrier were the prior plan to be still in effect.

e. The succeeding carrier, in applying any deductibles, individual or family stop-loss provisions limiting out-of-pocket payments, or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions and stop-loss provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible and stop-loss provisions of the prior carrier's plan but only to the extent those expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar stop-loss or deductible provision. Nothing in this rule shall be deemed to prevent a succeeding carrier's plan from having stop-loss levels or deductible amounts that are higher than those specified in the prior carrier's plan. For example, if during the benefit period during which replacement of the prior carrier has occurred an insured had also incurred $250 in eligible expenses, these expenses would have satisfied the $250 deductible of the prior carrier. However, if the prior carrier has a $500 deductible, crediting this $250 of incurred expenses to the succeeding carrier's deductible would only partially satisfy that deductible; and

f. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a

statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. Any determination of the benefits of the prior plan which shall be made shall be made in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

(4) Whenever there is a replacement of a carrier's benefit plan by the benefit plan of another carrier, the insureds, subscribers or members who were active recipients of mental health services under the prior carrier's plan shall be entitled to continue to receive mental health services from the same mental health provider who provided the services received while the insured, subscriber or member was an active recipient of mental health services under the prior carrier's plan.

(5) The entitlement to receive services pursuant to (4) above shall:

a. Continue for one year following the effective date of the new carrier's benefit plan;

b. Override any provisions in the replacing carrier's plan requiring the insured, subscriber or member to receive mental health services from mental health providers who have contracted with the replacing carrier to be part of the replacing carrier's provider network;

c. Override any provisions in the replacing carrier's plan that reduce or eliminate benefits for mental health services whenever such services are received from a mental health provider who has not contracted to be part of the replacing carrier's network;

d. Be provided to any insured, subscriber or member who, during an open enrollment period, changed from a benefit plan sponsored by the employer to another benefit plan sponsored by the employer;

e. Be subject to any provisions of the replacing carrier's plan requiring mental health services to be medically necessary, as defined in the replacing carrier's plan;

f. Be subject to any provisions of the replacing carrier's plan requiring mental health services to be preauthorized by the replacing carrier or its utilization review agent;

g. Be subject to the provision of proof of receipt of prior services while the prior carrier's plan was in effect as follows:

1. The insured, subscriber or member shall be responsible for providing such proof in the form of:

(i) An explanation of benefits form from the prior carrier;

(ii) A letter from the provider who provided the services attesting to the fact that services were provided together with the dates such services were rendered; or

(iii) Any other documentation which the replacing carrier determines to be acceptable as proof.

h. Be subject to verification that the provider of services under the prior carrier is protected by a malpractice policy with coverage of at least $1,000,000 per single incident and at least $3,000,000 in the aggregate.

(6) While the entitlement provided pursuant to (4) above is in effect, benefits shall be paid by the replacing carrier as if the insured, subscriber or member were receiving mental health services from a mental health provider who has contracted with the replacing carrier.

(7) The replacing carrier shall not be required to make direct benefit payments to a non-network provider nor shall this provision operate in any way to increase the liability of the replacing carrier above what its liability would be if the mental health services were received from a contracting mental health provider who is reimbursed on a fee-for-service basis.

Ins 1901.06 General Rules and/or Prohibited Policy Provisions.

(a) No policies or riders for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to a dividend policy or rider.

(b) Individual accident and health policies providing a "return of premium" or "cash value benefit" are prohibited unless such policies comply with the requirements of Part Ins 402.

(c) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(d) Rules respecting the use of preexisting condition exclusion or limitation provisions are as follows:

(1) Preexisting condition exclusion or limitation provisions, other than those subject to the stricter standards specified under Ins 1901.04(c)(4), Ins 1902.07(a)(1) or RSA 415-D:7 shall not exclude coverage of any preexisting condition unless:

a. The condition manifested itself within a period of 2 years prior to the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

b. Medical advice or treatment was recommended or received within a period of 2 years prior to the effective date of coverage.

(2) In order to determine if any preexisting conditions exist prior to the issue of coverage, insurers shall be permitted to ask questions of an applicant on an application with respect to any health condition of any person to be covered by the policy applied for by the applicant.

(3) Insurers shall be permitted the use of exclusion riders for the purpose of excluding specifically named or described preexisting diseases, physical conditions or extra-hazardous activities unless the use of such exclusion riders is otherwise not permitted by another provision of this part, other rules of the insurance department, or any state or federal law.

(e) Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability, nor in the case of disability income benefits shall

any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(f) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit exceeds the other benefits.

(g) Any individual accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are less than the maximum amount payable under the policy.

(h) No group, blanket or individual accident or health policy issued or delivered in this state may exclude coverage for reconstructive surgery related to:

(1) Surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and

(2) Congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

(i) No policy providing disability income protection, as defined in Ins 1901.03(e), shall in any way condition benefit payments for "total disability" on "continuous confinement within doors" or language of similar import.

(j) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RSA 415:2 and 3.

(k) With respect to any accident and health policy sold to any individual age 65 or over and any group insurance certificate sold directly to any such individual, no insurance company, broker or agent shall collect, or otherwise accept, any consideration for the policy or certificate in excess of the premium charge for a period of one month until such time as the free look provision provided by the policy or certificate has expired. At no time, shall any insurance company, broker or agent collect, or otherwise accept, more than a single annual premium as consideration for the issue or renewal of any accident and health policy or certificate if any insured under the policy is age 65 or older. This provision, however, shall not apply to policies providing accident only benefits nor to policies with an annual premium of less than $100.

(l) No policy or group certificate providing accident and health insurance benefits shall use the terms "major," "comprehensive," "catastrophic" or words of similar import in its title or brief description unless such policy or group certificate satisfies the minimum benefit standards for major medical expense coverage prescribed by Ins 1901.03(b)(4).

(m) No insurer providing basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, or any combination thereof on a group or group-type basis shall use riders or endorsement to exclude, limit or reduce the coverage or benefits of any individual insured because of a specific health condition indicated by the medical history of the insured unless the condition to be excluded is one of the conditions listed below. An insurer may also exclude 2 or more conditions by rider or endorsement provided each of the conditions to be excluded is listed below.

(1) The following health conditions may be excluded by rider or endorsement to the above coverage’s if indicated by the medical history by the insured:

a. Acne, acne scarring or treatment for it;

b. Alcoholism, drug addiction, or the abuse of alcohol or drugs;

c. Burn scars, provided the area involved is named, and treatment for them;

d. Club foot, any such disorder of the foot, provided the foot, right or left, is specified, or treatment for it;

e. Headaches - migraine or headaches;

f. Infertility;

g. Psoriasis;

h. Any disorder of the skin except skin cancer provided the skin disorder or condition is named; or

i. Temporomandibular joint pain, dysfunction syndrome or myofacial pain dysfunction.

(2) When one carrier replaces another carrier, the succeeding carrier shall be permitted to use an exclusion rider or enforcement to modify the coverage of any insured who was covered by the prior carrier if the condition to be excluded is listed under (1) above, but only if the prior carrier had similarly restricted the coverage of that insured.

(n) With respect to any applicant for accident and health insurance under either an individual policy or a group insurance certificate as either the primary insured or as a dependent, no insurer shall make an adverse underwriting decision for such applicant because of a history of treatment for a mental or nervous condition except where one or more of the following are found to apply:

(1) The applicant has been treated for a mental or nervous condition on at least one occasion within the last 3 months;

(2) The applicant has, within his or her lifetime, been confined as an inpatient in a hospital or other treatment facility because of a mental or nervous condition; and

(3) The applicant has had, within his or her lifetime, 3 or more treatments of any kind for a mental or nervous condition while not confined in a hospital or other treatment facility.

Ins 1901.07 Disclosure Requirements.

(a) Outline of coverage disclosure requirements are as follows:

(1) No policy of individual accident and sickness insurance or nonprofit service corporation subscriber contract shall be delivered or issued for delivery in this state unless:

a. Where the policy or contract is a direct response insurance product, an outline of coverage accompanies the policy upon delivery; or

b. In all other cases, the outline of coverage is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of the outline of coverage signed by the applicant is made part of or attached to the application when it is submitted to the insurer or nonprofit service corporation.

(2) The outline of coverage shall be clearly identified as such, shall accurately describe the policy or contract and its provisions in a clear and concise manner and shall specifically contain the following:

a. The name and principal address of the insurer or service corporation;

b. A statement of identification of the policy or contract which shall set forth the applicable category or categories of coverage as prescribed in RSA 415-A:3;

c. A description of each of the principal benefits and coverage's, including the benefit amounts, duration or limits, elimination periods, inner limits, deductibles, co-payment provisions and any other items appropriate to the coverage provided;

d. A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability, including any rights of cancellation reserved to the insurer;

e. A description of the exceptions, reductions and limitations contained in the policy or contract, including the preexisting condition provision, if any, and the circumstances under which any reduction provisions become operative; and

f. Each outline of coverage shall include the following statement: "Read your policy carefully - this outline of coverage provides a very brief description of some important features of your policy. However, the policy itself sets forth in detail the rights and obligations of both you and the company. It is important that you read your policy carefully."

(b) In the event that a policy or contract is issued on a basis other than that applied for, a disclosure statement properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name - "NOTICE." Read this disclosure statement carefully. It is not identical to the disclosure statement provided upon application and the coverage originally applied for has not been issued.

(c) This section shall not apply to group or blanket accident and health insurance policies, nor shall it apply to any conversion policy.

Ins 1901.08 Applicability.

(a) This part shall apply to all policies of accident and health insurance:

(1) On its effective date with respect to all forms not previously approved;

(2) One hundred and twenty days after its effective date with respect to policies thereafter delivered or issued for delivery in this state;

(3) One hundred and twenty days after its effective date with respect to any individual accident and health policies which are thereafter amended to reduce or limit benefits or coverage's without a compensating premium consideration; and

(4) One hundred and twenty days after its effective date with respect to any group or blanket policies which are thereafter renewed or amended.

(b) Approval is hereby withdrawn effective 120 days after the effective date of this part as to all forms of accident and health insurance which have previous approval but which do not comply with this part.

(c) All accident and health insurance forms submitted to this department in accordance with Ins 401, and received by this department on or after the effective date of Ins 1901 shall include as part of the transmittal letter for such submission the following statement of certification: "(company name), to the best of its knowledge and belief, does hereby certify that the accompanying form(s) as identified by the listing attached hereto, does (do) comply with all applicable sections of Ins 1901, MINIMUM STANDARDS FOR ACCIDENT AND HEALTH INSURANCE, which pertain to such form(s)."

Dated: _____

By: _____
(name and title of person signing)

The above statement may appear as an attachment to the transmittal letter.

Ins 1901.09 Penalties. Any insurer, agent, broker, or any person, firm, association or corporation violating any provisions of this part or who shall issue, deliver, use, sell, offer for sale, invite offers for or inquiries about, or dispose of any document in violation of the provisions of this part may:

(a) Have its certificate of authority indefinitely suspended or revoked at the discretion of the commissioner; and/or

(b) Be subject to an administrative fine not to exceed $2,500 for each violation. Repeated violations of the same chapter or part shall constitute separate fineable offenses.

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